

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

EMEND-(aprepitant)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext.and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY**

INFORMATION: Used in combination with corticosteroid and other 5HT3 agents, is indicated for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy including high dose Cisplatin

CRITERIA:

Patients receiving the following chemotherapy regimens that are classified by the National Comprehensive Cancer Network (NCCN) as high emetic risk may receive Emend as a first-line treatment for the prevention:

- ▶ Cisplatin $\geq 50\text{mg/m}^2$
- ▶ Cyclophosphamide $\geq 1,500\text{mg/m}^2$
- ▶ Dacarbazine
- ▶ Mechlorethamine
- ▶ Procarbazine (oral)
- ▶ Streptozocin
- ▶ Altretamine
- ▶ Carmustine $\geq 250\text{mg/m}^2$
- ▶ AC combination defined as wither doxorubicin or epirubicin with cyclophosphamide
- ▶ Patients on other chemotherapy regimens require a failure on trial of any ONE of the 5HT3 medications (e.g. Zofran, Anzemet, Kytril, or Aloxi)

AUTHORIZATION:

6 months

3 doses per chemotherapy session

RE-AUTHORIZATION:

Telephone request by physician office or pharmacy.